

No. 2  
M-8-43  
5-17-39  
X37823

State File No. \_\_\_\_\_

Registrar's No. 5

FILED FEB 14 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 5390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

300

1. PLACE OF DEATH:

(a) County Dent  
(b) City or town Springbrook  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) \_\_\_\_\_  
(d) Length of stay: In hospital or institution X \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community most of his life.  
years, months or days)

3. (a) PRINT FULL NAME Joseph M. Plank

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced marrie

6. (b) Name of husband or wife Laura Plank 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Feb 16 1871  
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Dent Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business X

12. Name Iohn Plank

13. Birthplace Dent Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Day

15. Birthplace Dent Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Jed Plank

(b) Address Salem Mo

17. (a) burial (b) Date thereof 1/28/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar rive

18. (a) Signature of funeral director W. H. Spencer  
(b) Address Salem Mo

19. (a) 1-27-45 (b) Joe D. Mc  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent 33  
(c) City or town Rural 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. X (If rural, give location) 0  
(e) Citizen of foreign country? X (Yes or No) 0  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26  
year 1945 hour 10 minute A M.

21. I hereby certify that I attended the deceased from Jan 1945 to Jan 25 1945  
that I last saw him alive on Jan 25 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular  
Renal Disease  
Due to Influenza

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 131a  
Of operations ✓  
Of autopsy no

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) ✓  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? Home  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? no (e) Means of injury \_\_\_\_\_  
3. Signature W. H. Spencer (M. D. or other) \_\_\_\_\_  
Address Salem Mo Date signed 1-27-45

RECEIVED

District Health Officer No. 5.

District File Number 245-90

Date Filed 2-12-45-

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Carl H. Jensen

Licensed Embalmer No. 2970

P. O. Address Salem Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.